Assignment:_____
Schedule:_____
Date:_____

CONNECTICUT VETERANS HOME - VOLUNTEER APPLICATION

(Please Print)

Name:	LAST	FIRST	MIDDLE INITIAL
Address:	STREET	CITY:	STATE: ZIPCODE
Date of Birth	MONTH	DAY	YEAR
Person to contact in case of Emergency	Name	Address	Phone Number / Cell Phone Number
Phone # / **E Mail**			

REFERENCES: Please provide COMPLETE Mailing Address

NAME	ADDRESS	PHONE	YRS KNOWN
1.			
2.			
3.			

What Skills or hobbies would like to share?

Please circle Musical performance Art Reading Writing

Library Cart Pet Therapy Wheelchair Escort Board and Card Games

Wii games Computer helper Memory Books Bulletin Boards

Other: (please explain)

Volunteers are asked to commit a minimum of 3 hours per month
Hours for all volunteers: 9:30am to 3:30 pm, Monday – Friday, additional hours by arrangement

I would like to work: (please circle)	Monday	Tuesday	Wednesday	Thursday	Friday
	am/pm	am/pm	am/pm	am/pm	am/pm

I am ONLY available evenings or Weekends. Please check here_____. Which evenings (6 to 9 pm)? (circle) M Tu W Th F
Weekend times Sat (am or pm) Sun (am or pm)?

Are you volunteering in affiliation with a veteran's organization/church/school, other group or special program?

_____ Yes _____No

If yes please provide name of group/church/school or special program:

I agree complete the training classes, honor patient privacy rules and be available to schedule a minimum of 1 day per week_____ or 1 day per month _____ for a minimum of 3 hours per month.

Signature: **Date:**

Revised 11/2014

Please Return to: Barbara.vaillancourt@ct.gov or
Barbara Vaillancourt
Department of Veterans' Affairs, 287 West Street, Rocky Hill, CT 06067

DEPARTMENT OF VETERANS AFFAIRS
Rocky Hill, CT

Name:_____
Assignment:_____

Volunteer Medical History Form

Volunteers of the Department of Veterans' Affairs, Rocky Hill, CT, involved in direct patient care are required to have a medical history submitted for purposes of health maintenance of the individuals and patients during the course of the volunteer's work.
A physical examination performed by the Volunteer's private physician may be required if the medical history indicates a possible health problem(s).

Medical History (to be completed by the applicant) This history will be confidential.

Name:	**LAST**	**FIRST**	**MIDDLE**
Have you any mental or physical disabilities at this time	**Please circle: Yes**	**No**	If yes please explain:
List major illnesses and operations you have had			

Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Heart Disease			Joint Disease or "Trick Joint"		
Lung Disease			Backache or Back Problems		
Asthma			Sciatica or any Neuritis		
Shortness of breath			Epilepsy or Convulsions		
Blood Conditions			Head injury or loss of consciousness		
Tuberculosis			Alcohol or Drug Addiction		
Positive Tuberculin Test			Mental Disorder		
Liver Condition			Eye Disorder		
Rheumatism or Arthritis			Ear Disorder		
Chronic Diarrhea			Chronic Cough		
Chicken Pox			Measles		

If you answered yes to any of the above please give a brief explanation:

1) Have you experienced any of the following symptoms in the past year?
   a) Cough for more than 3 weeks? Yes No
   b) Sputum Production Yes No
   c) Hemoptysis (coughing up blood or Bloody Sputum)? Yes No
   d) Unexplained weight loss? Yes No
   e) Fever, Chills? Yes No
   f) Night sweats? Yes No
   g) Persistent shortness of breath? Yes No
   h) Unexplained fatigue? Yes No

2) Have you had contact with anyone with active tuberculosis disease in the past year? Yes No

3) Have you ever had a positive skin or blood test for TB? If yes, what year?

4) Have you ever been told by a doctor or healthcare provider that you had active TB?

Applicant Signature:_____ Date:_____

Reviewed by Hospital Epidemiologist: _____ Date:_____

Physical Exam Required: NO_____ YES_____